STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2013				
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE  CHURCH AVE			
LUTHER	AN COMMUNITY	HOME	SEYMOUR, IN 47274				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES  NCY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F000000	State Licensul included the Ir Complaint INC Complaint INC Unsubstantiate evidence.  Survey dates: 8, 9, and 10, 2 Facility number Provider number: Survey team: Diana Sidell R Sunny Jungcla 4, 5, 6, 9, and Jennifer Carr 6, 9, and 10, 2 Debora Barth and 6, 2013)	20132376 - ed due to lack of  September 3, 4, 5, 6, 2013  er: 000347 per: 155715 100275440  EN, TC aus RN (September 3, 10, 2013) RN (September 3, 4, 5, 2013)  rpe:	F000000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept the plan of correction as our credicallegation of compliance.	e ts		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

LWD111

Facility ID:

000347

If continuation sheet

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number:  155715	A. BUILDING  B. WING	00	COMPI 09/10	LETED
	PROVIDER OR SUPPLIER  AN COMMUNITY HOME	111 W (	ADDRESS, CITY, STATE, ZIP COD CHURCH AVE DUR, IN 47274	E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Census payor type: Medicare: 12 Medicaid: 56 Other: 66 Total: 134 Residential sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on September 19, 2013, by Cheryl Fielden, RN				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet

Page 2 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			
		155715	B. WING		09/10/2013	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹		CHURCH AVE		
LUTHER	AN COMMUNITY F	HOME		OUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
		·	TAG	DEFICIENCY)	DATE	
TAG F000156 SS=B	483.10(b)(5) - (10) NOTICE OF RIG CHARGES The facility must orally and in writi resident understa all rules and regu- conduct and resp in the facility. Th the resident with State developed Act. Such notific or upon admission stay. Receipt of amendments to it writing.  The facility must entitled to Medica the time of admis or, when the resident may amount of charged; the services that the the resident may amount of charge inform each resident made to the item paragraphs (5)(i)  The facility must before, or at the the periodically durin services available charges for service Medicare or by the  The facility must	inform the resident both and in a language that the ands of his or her rights and alations governing resident bonsibilities during the stay in a language that the ands of his or her rights and alations governing resident bonsibilities during the stay in a language that the notice (if any) of the under §1919(e)(6) of the ation must be made prior to on and during the resident's such information, and any it, must be acknowledged in the said benefits, in writing, at a sision to the nursing facility dent becomes eligible for the semand services that are and facility services under the resident may hose other items and facility offers and for which be charged, and the set for those services; and dent when changes are is and services specified in (A) and (B) of this section.  Inform each resident time of admission, and ig the resident's stay, of the in the facility and of the services, including any one services, including any one services, including any one services and the services, including any one services, including any one facility's per diem rate.	TAG	DEFICIENCY)	DATE	
	of legal rights wh	ich includes:				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet

Page 3 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155715		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING			(X3) DATE SURVEY COMPLETED 09/10/2013		
			B. WING	TREET A	DDRESS, CITY, STATE, ZIP CODE	007.107	
	PROVIDER OR SUPPLIEF AN COMMUNITY H		1.	11 W C	CHURCH AVE UR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II	)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
	· ·	he manner of protecting ınder paragraph (c) of this					
	A description of t procedures for es Medicaid, includir assessment under determines the enon-exempt reso institutionalization community spous resources which available for payrinstitutionalized sor her process of Medicaid eligibility. A posting of name telephone number client advocacy grands survey and certification includes the program, the program, the program as statement complaint with the	es, addresses, and ers of all pertinent State groups such as the State cation agency, the State he State ombudsman tection and advocacy Medicaid fraud control unit; that the resident may file a e State survey and					
	abuse, neglect, a resident property	cy concerning resident and misappropriation of in the facility, and with the advance directives					
	name, specialty,	inform each resident of the and way of contacting the sible for his or her care.					
	facility written info residents and ap and written inform	prominently display in the ormation, and provide to plicants for admission oral nation about how to apply care and Medicaid benefits,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet Page 4 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
		155715	A. BUII B. WIN		<del></del>		/10/2013	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF	₹						
LUTUED	A N.I. COOR AR ALLIN HET V. I.	IOME			CHURCH AVE			
LUTHER	AN COMMUNITY F	HOME		SETIVIC	DUR, IN 47274			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	and how to recei	ve refunds for previous						
	payments covere	ed by such benefits.						
			F00	0156	F 156 Notice of Rights, Rules	,	10/07/2013	
					Services, and Charges (Medic	are		
	Based on reco	rd review and			Non-Coverage Letters)It is the			
		facility failed to ensure			policy of this facility to ensure			
					liability and appeal notices are			
		peal notices were given			given in a timely			
	•	nner for 3 of 3 residents			manner.Corrective Action For			
	who fit the crite	eria for liability notices.			Resident Affected: Residents	.		
	(Residents #11	1, #26, and #127)			#11, 26, and 127 were already			
					discharged from the facility at			
	Findings include	le·			time of survey.Other Resident Having The Potential To Be	٥		
	l manigo molac	.0.			Affected: All residents with			
	1 During on it	otomiow on 00/05/12			Medicare benefits have the			
	_	nterview, on 09/05/13			potential to be affected.System	nic		
	·	ne Administrator			Changes and Steps to Assure			
	indicated that t	the Notice of Medicare			Deficient Practice Does Not			
	non-coverage	for Resident #11 could			Recur: The Admissions Direct	tor		
	not be found.	She indicated that the			who is responsible for these			
	Social Services	s Department could not			notices completed her Social			
		ting it signed and			Service Designee course on			
		hat "It is normally in the			08/09/2013. She received			
		_			training on these notices in tha			
	medical record	1.			training. Appropriate member	s of		
					the leadership team were provided a written copy of the			
	2. On 09/05/1	3, the Notice of			instructions for use of the Noti	ا م		
	Medicare Non-	-Coverage letter for			of Medicare Non-Coverage			
	Resident #26 v	was reviewed. The			Letter. (Attachment 4 titled Fo	rm		
		d that Resident #26's			Instructions for the Notice of			
		ices would end on			Medicare Non-Coverage). All			
					members verbalized			
		etter was signed by			understanding of the			
		on 04/25/13. An			requirements and signed off o			
	· ·	9/5/13 at 2:30 p.m.,			the form. All future notices sh			
	with the Admis	sion Coordinator			be provided in accordance to t	he		
	indicated that t	this was a one day			CMS form instructions.			
	notification.	,			(Attachment 5 titled Notice of			
					Medicare Non Coverage Lette	rs		
					Education). Monitoring of			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155715	B. WIN		<del></del>	09/10/2013
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEI	₹			CHURCH AVE	
	AN COMMUNITY F	HOME		SEYMC	OUR, IN 47274	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	•	DATE
		3, the Notice of			Corrective Action: All discharg records will be reviewed to	ged
		-Coverage letter for			ensure that the appropriate no	tice
		was reviewed. The			was given in the appropriate ti	
		d that Resident #127's			frame. This audit will begin wi	th
		ices would end on			all discharges in the month of	
		signature line, dated			October. (Attachment 6 titled Medicare Non Coverage Lette	re
	06/12/13, was noted "received verbal				Discharge Audit). Audit result:	
	confirmation fr	•			will be reviewed by the Quality	
	aware[Resident #127's son] of [Resident #127's] skilled /OT Tx (occupational therapy) services				Assurance Committee monthly	
					for six months. If appropriate	
					documentation is in the record	
	ending but cor	itinuing a RNP			100% of the time, monthly monitoring will be stopped and	
	(restorative nu	rsing program) on			random audits will occur. A	
	Speech Tx (Th	nerapy)." An interview,			sample size of 25% will be	
	on 09/05/13 at	2:30 p.m., with the			completed monthly. If	
	Admissions Co	oordinator, indicated			opportunities for improvement	are
	she only had th	ne verbal ok and no			identified through the random	ıt
	further docume				audit, a full audit will resume. after six months of random au	II
					100% compliance continues,	
	4. Interview w	ith the Admission			auditing will stop.	
	Coordinator, o	n 9/5/13 at 2:40 p.m.,				
		nad not given any				
		timate of costs when				
		as discharged from				
		remained in the facility.				
		ated none of the				
		asked for a demand				
	bill.	action of a domain				
	~''''					
	5 On 09/06/1	3, at 11:28 a.m., the				
		nstructions for the				
	1	care Non - Coverage				
		S - 10095" was				
	, ,					
		e first sentence of this				
	ι τorm reads, "A	Medicare health				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet

Page 6 of 42

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION  IDENTIFICATION NUMBER:  155715	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE (COMPL 09/10/	ETED	
	PROVIDER OR SUPPLIER  AN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE  111 W CHURCH AVE  SEYMOUR, IN 47274				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	provider must give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to enrollees receiving skilled nursingno later than two days before the termination date to the provider not later than two days before the termination of services."  3.1-4(f)(3)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet

Page 7 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPLETED	
		155715	B. WING	ING		09/10/	2013
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	1			CHURCH AVE		
LUTUED	AN COMMUNITY H	IOME			UR, IN 47274		
LUTHER	AN COMMUNITY F	IOME		SETIVIO	OR, IN 47274		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PI	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000279	483.20(d), 483.20						
SS=D		PREHENSIVE CARE					
	PLANS A facility must use the results of the assessment to develop, review and revise						
	the resident's con	nprehensive plan of care.					
	The facility must develop a comprehensive care plan for each resident that includes						
		ctives and timetables to					
	meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.						
	•	st describe the services					
		nished to attain or maintain					
		hest practicable physical,					
		hosocial well-being as					
		183.25; and any services					
		vise be required under not provided due to the					
	-	e of rights under §483.10,					
		t to refuse treatment under					
	§483.10(b)(4).						
	Based on reco	rd review and	F0002	<sub>279</sub>	F 279 Comprehensive Care		10/07/2013
		acility failed to develop			Plans. It is the policy of this		
		ated to catheter use for			facility to use the results of the		
	•				assessment to develop, review	<i>I</i> ,	
		ts reviewed. (Resident			and revise the resident's		
	#28)				comprehensive plan of		
					care.Corrective Action for		
	Finding include	2:			Resident Affected: The resider	ıt's	
					care plan was reviewed and a		
	The clinical rec	ord for Resident #28			care plan for use of a Foley catheter was added to the		
		on 09/06/13, at 10:07			resident's plan of care.		
		rd indicated the			(Attachment 7 titled Foley		
		dmitted, on 02/23/13,			Catheter Care Plan) .Other		
					Residents Having the Potentia	I to	
	_	that included benign			be Affected: All residents with		
		trophy and urinary			catheters have the potential to	be	
	retention. A pr	ogress note dated			affected. The care plans of the	;	
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet

Page 8 of 42

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  09/10/2013
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY H  (X4) ID SUMMARY ST PREFIX (EACH DEFICIEN TAG REGULATORY OR  03/24/13 indicat was performed void showed a milliters. After physician, an o 03/25/13 for: " anchor tonite th name] in am fo	IDENTIFICATION NUMBER:  155715  IOME  TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  Ited a bladder scan at 8 a.m., and the post residual of 380  follow up with the rder was received on Urinary retention hen call [physician's r further instructions."	A. BUILDING B. WING  STREET A  111 W		COMPLETED 09/10/2013  (X5) COMPLETION DATE  re nnce of s and uring nn DOON lire
Review of the Administration documentation foley catheter put The record did related to the form An interview with 09/05/2013 at 4	Freatment Record indicated for monthly change for per orders.  not include a care plan pley catheter.  th the DON, on 4:32 p.m., indicated ble to find a plan of		residents with a new order f catheter. An audit of care pl residents with catheters will completed weekly to assure appropriate care plan for ca use is in place. (Attachmen 8 titled Catheter Care Plan Audit). Monitoring of Correct Action: Audit results will be reviewed by the Quality Assurance Committee mont for six months. If appropriate documentation is completed 100% of the time, weekly au will be stopped and monthly audits will begin. A sample of 25% will be completed. If opportunities for improveme identified through the rando audit, a full audit will resume after 6 months of random at 100% compliance continues auditing will stop.	or a ans of be an theter t  ctive  thly e d dudits r size ent are m e. If

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet

Page 9 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
		155715	B. WIN			09/10/2013	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P.	ROVIDER OR SUPPLIER	<u>t</u>		111 W (	CHURCH AVE		
LUTHER	AN COMMUNITY H	IOME			OUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE	re '	COMPLETION
		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F000312 SS=D	483.25(a)(3) ADL CARE PROVERESIDENTS A resident who is activities of daily necessary service nutrition, groomin hygiene.  Based on obse and record revireposition 1 of of 35 reviewed (Resident #52) Findings included On 9-3-13 at 10 #52 was observed to be and in the samult:15 A.M., 12 and at 2:35 P.M.  On 9-4-13 at 95 was observed so served to served to served to served to 9-4-13 at 95 was observed so served so ser	le: 0:01 A.M., Resident ved sitting in a wheel ivity/dining room. The el chair had a foam arm, and was pulled ble. The resident was in the same position e area at 10:30 A.M., :01 P.M.,12:33 P.M.	F00	0312	F 312 ADL Care Provided For Dependent Residents. It is the policy of this facility to ensure resident who is unable to carry out activities of daily living received the necessary service to maintain good nutrition, grooming, personal hygiene, a oral hygiene.Corrective Action Resident Affected: The carepla of resident #52 was reviewed assure the turning and/or repositioning approach was included in the care plan. The nurse orders for this resident were reviewed to assure turning and repositioning nurse orders were in place and sent to the C.N.A. task list in Optimus. Th resident will be included in the audit described below at least once per week. If the audit changes to weekly, then this resident will be included in the audit at least once per month.Other Residents Having the Potential to be Affected: Earesident dependent upon staff	es aa des nd for an co	DATE 10/07/2013
	breakfast.	sisted with eating her 0:00 A.M., the resident			turning and/or repositioning ha the potential to be affected. Th care plans of these residents were reviewed to assure the	s	
		in the activity-dining			turning and repositioning approach was included in the	skin	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet

Page 10 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00		COMPLETED		
		155715	A. BUII B. WIN			09/10/	2013
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R			CHURCH AVE		
LUTUED	AN COMMUNITY I	JOME					
LUTHER	AN COMMUNITY	TOME		SETIVIC	DUR, IN 47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SHOULD BE COMI APPROPRIATE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG			DATE
	room, sitting in	her wheel chair, with			care plan. The nurse orders o	f	
	chair alarm an	d foam cushion in			each of these residents were	_1	
	place. A stuffe	d dog and some scarf's			reviewed to assure turning an		
	were placed in	_			repositioning nurse orders we place and sent to the C.N.A. t		
					list in Optimus, the	ask	
	The resident was continually				electronic medical		
		<u> </u>			record. Systemic Changes an	d	
	observed in her wheel chair on 9-4-13 from 10:40 A.M. thru 11:45 A.M. in the same position. The resident was				Steps to Assure Deficient		
					Practice Does Not Recur:		
					Nursing staff education		
	not repositione	ed throughout this			was initiated beginning		
	observation pe	eriod.			September 25, 2013 and will I	be	
					complete by 10-07-2013.		
	An interview, o	on 9-4-13 at 11:45 A.M.,			(Attachment 9 titled 2013 Ann		
	•	d with CNA #5 and CNA			Survey Plan of Correction). As audit will be conducted each	1	
		's indicated they had			business day on one randoml	v	
		dent #52 to the			selected resident to assure	,	
					appropriate documentation of		
		nged her brief, nor			turning and/or repositioning is		
		osition. They both			completed. In addition, that		
	further indicate	ed the resident was a			resident will be checked visua	•	
	two person as:	sist.			at multiple random times durir	ng	
					the business day to assure a		
	On 9-4-13 at 1	:53 P.M., the resident			position change has occurred		
		sitting in her wheel			(Attachment 10 titled Turning and/or Repositioning Audit).		
		ing/activity room.			Monitoring of Corrective Actio	n·	
		inigradiatity room.			Audit results will be reviewed		
	On 0 4 42 at 3	20 D.M. the resident			the Quality Assurance Commi		
		:30 P.M., the resident			monthly for six months. If		
		in her wheelchair, at			appropriate care		
	the table, in th	e dining/activity room.			and documentation is completed		
					100% of the time, daily audits		
	On 9-4-13 at 3	:40 P.M., a careplan			be stopped and weekly audits		
	dated 1-21-13	was reviewed, and			begin. A sample size of 25%		
		esident was at risk for			be completed. If opportunities	s for	
		n related to: decreased			improvement are identified through the random audit, a fu	ш	
	mobility, cogni				audit will resume. If after 6	411	
					months of random audits, 100	ا%	
	i diabetes, inte	rventions included but			I months of fandom addits, 100	. , 3	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	LDING	NSTRUCTION  00	(X3) DATE S COMPL 09/10/	ETED
	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE CHURCH AVE JUR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	turn and repositions as needed, endout of bed daily and dry, pression wheelchair, mattress.  On 9-5-13 at 4 the form "CNA indicated the sithat Resident # between 7:00 / 9-3-13 and 9-4  An interview with (ADM), on 9-5-indicated Residert Resident # per CNA docur and 9-4-13. The explanation as wasn't repositioned from the explanationed from the explanationed from the explanationed from the explanationed from the expla	ith the Administrator 13 at 4:10 P.M., dent # 52 wasn't om 7 A.M. to 3 P.M. mentation on 9-3-13 ne ADM had no to why the resident on by the staff every 2 areplan/nursing orders		compliance continues, auditin will stop.	9	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet Page 12 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155715	B. WING		09/10/2013	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			CHURCH AVE		
LITUED	AN COMMUNITY H	IOME		DUR, IN 47274		
LOTTIEN	AN COMMONTT T	OME	SETIVIC	JON, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F000329	483.25(I)					
SS=D	DRUG REGIMEN	I IS FREE FROM				
	UNNECESSARY					
		rug regimen must be free				
		drugs. An unnecessary				
		when used in excessive				
		uplicate therapy); or for				
		n; or without adequate hout adequate indications				
		ne presence of adverse				
		nich indicate the dose				
	•	d or discontinued; or any				
		he reasons above.				
	Based on a comp	rehensive assessment of a				
	resident, the facili	ity must ensure that				
	residents who have	ve not used antipsychotic				
	•	en these drugs unless				
		g therapy is necessary to				
	•	ondition as diagnosed and				
		e clinical record; and				
		e antipsychotic drugs				
		ose reductions, and				
		entions, unless clinically n an effort to discontinue				
	these drugs.	if an enore to discontinue				
	Based on reco	rd raviow and	F000329	F 220 Hanasasan, Druga	10/07/2013	
			1.000323	F 329 Unnecessary Drugs (Tylenol Precautionary	10/0//2013	
		acility failed to prevent		Statement).It is the policy of the	is	
	•	cessive use of Tylenol		facility that each resident's dru		
	with a precaution	onary statement for 2		regimen must be free from		
	of 5 residents r	eviewed for		unnecessary drugs. Corrective	e	
	unnecessary m	nedications. (Residents		Action for Residents Affected:		
	#20 and 68)	`		Orders for all medications		
				containing acetaminophen for		
	Findings includ	le:		resident #20 and #68 were		
	Findings includ			reviewed. PRN administration		
		record for Resident #		was reviewed for these resider	nts	
		ed on 9/4/13 at 2:30		over a 30-day period and was		
	p.m. for medica	ation use. The		calculated with any routine		
	resident had di	agnoses which		medication doses. There were	-	
				instances of exceeding the dai	ıy	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet Page 13 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155715	ı	LDING		09/10/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
LUTUED	A N I O O A M AI IN II T \	IOME			CHURCH AVE		
LUTHER	AN COMMUNITY F	HOME		SEYMC	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	included, but w	vere not limited to:			recommended limit of 4000mg	J. A	
	stroke, intracta	ble pain, and			precautionary medication test		
	•	The most recent			with the statement "Do not		
		ite orders, dated			exceed 4000mg of		
					acetaminophen daily " was ad		
		ed the medications			to the EMR system to attach to	0	
	,	vere not limited to the			medications containing acetaminophen. This medicati	on	
		enol Extra Strength 500			test was added to each	OII	
	milligrams (mg	) one capsule daily	1		medication containing		
	(original order	date was 5/6/13);			acetaminophen for these		
	Tylenol 325 mg	g 2 tabs prn (as			residents. (Attachment 11 title	ed	
	•	n (every 4 hours) for			Medication Test Example). A		
	*	original order date was			care plan for acetaminophen ι	ıse	
		_			was added to each resident's		
	,	/lenol Arthritis 650 mg			plan of care. (Attachment		
	• •	up to 3 times per day			12 titled Acetaminophen Warn	ing	
		al order date was			Care Plan). Other Residents		
	5/6/13).				Having the Potential to be		
					Affected: All residents taking acetaminophen have the poter	otial	
	The Medication	n Administration			to be affected. The medication		
	Record (MAR)	for June, 2013 July,			orders for all residents were	•	
	2013 and Augu	-			reviewed for usage of		
	_	MAR indicated the			acetaminophen. Those resider	nts	
					with the potential to exceed		
		eceived the prn Tylenol			4000mg daily based upon thei		
	_	on 8/25/13 during the			routine orders in addition to us		
		eviewed. There were			of every prn dose available we	ere	
	•	ry statements for what	1		identified. PRN administration	nto	
	would constitut	te and excessive dose			was reviewed for these reside over a 30-day period and was	IIIS	
	for the resident	t on any of the orders			calculated with any routine		
	or in the reside				medication doses. There were	no	
					instances of exceeding the dai		
	The pharmacis	t had reviewed the	1		recommended limit of 4000mg	•	
	•	ication orders on			precautionary medication test		
					with the statement "Do not		
		24/13 with no Tylenol			exceed 4000mg of		
	recommendation	ons.			acetaminophen daily" was add		
					to the EMR system to attach to	ס	
	2. The clinical	record was reviewed			medications containing		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155715		LDING		09/10/	2013
			B. WIN		ADDRESS CITY STATE TID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
LUTUED	A N.I. O O D AD ALL IN LITTY / I	IOME			CHURCH AVE		
LUTHER	AN COMMUNITY F	HOME		SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	on 9/5/13 at 8:	55 a.m. for Resident#			acetaminophen. This medicat	ion	
	68. He had dia	agnoses which			test was added to each		
		vere not limited to:			medication containing		
	hypertension, peripheral neuropathy,				acetaminophen for each of the	ese	
	1 .	oarthritis, glaucoma,			residents. A care plan for	nd to	
		oartifitis, glaucoma,			acetaminophen use was adde each resident's plan of	ีน เบ	
	and dementia.				care.Systemic Changes and		
					Steps to Assure Deficient		
		rewrite orders for			Practice Does Not Recur: A		
	medications, m	nost recently reviewed			medication test with the		
	by the physicia	n on 8/3/13, indicated			precautionary statement "Do i	not	
	the resident wa	as receiving Norco			exceed 4000mg of		
	5/325 (5 milligr	_			acetaminophen daily" was add	ded	
	, ,	and 325 mg of Tylenol)			to the EMR system. During		
		very 4 hours) for pain			review of new and admission		
	• •				orders, DON or designee will	·h	
	, , ,	ered 8/22/12). In			assure the medication test with the precautionary statement is		
	· ·	was an order for			attached to any orders for	5	
	1 -	tabs q4h prn (as			medications containing		
	necessary) (or	iginally ordered on			acetaminophen. An audit of 6		
	8/22/12).				residents per week will be		
					conducted to assure they hav	е	
	The Medication	n Administration			not exceeded the recommend		
		for July, 2013, August,			daily dosage limit. (Attachme		
	, , ,	tember, 2013 was			13 titled Acetaminophen Audi	t).	
	•				Nursing staff education was	40	
		resident had received			initiated on September 25, 20		
	, ,	ce each day on			and will be complete with all s by 10-07-2013. (Attachment		
	1	3, 8/11/13, 8/27/13, and			titled 2013 Annual Survey Pla		
	9/13/13.				Correction). Monitoring of	01	
					Corrective Action: Audit result	ts	
	3. Review of t	he Nursing 2013 Drug			will be reviewed by the Quality		
		m the A Unit of the			Assurance Committee monthl	у	
	· ·	e 67, indicated the			for six months. If appropriate		
	following: "Ir				documentation is completed		
	_				100% of the time, weekly aud	its	
		Its: 325 to 650 mg			will be stopped and monthly		
	every 4 to 6 ho				audits will begin. A sample si	ze	
	extended-relea	ase caplets P.O. (by			of 25% will be completed. If		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155715	B. WIN	IG		09/10/	2013
NAME OF P	ROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TOTAL OF T	NO VIDEN ON BOTTELET	•			CHURCH AVE		
LUTHER	AN COMMUNITY H	HOME		SEYMO	OUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	,	B hours. Maximum , 4 g			opportunities for improvement	are	
	, ,	For long term therapy,			identified through the random audit, a full audit will resume. I	f	
	don't exceed 2.6 g daily unless prescribed and monitored closely by health care provider"				after 6 months of random audi		
					100% compliance continues,	,	
					auditing will stop.		
	4. Interview w	ith the Director of					
	Nursing, on 9/5	5/13 at 10:30 a.m.,					
	indicated she h	nad contacted the					
	pharmacist. S	he indicated he had					
	indicated he di	d not recommend a					
	precautionary	statement until the					
	resident was c	lose to or over the					
	recommended	dose.					
	3.1-48(a)(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet Page 16 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
		155715	B. WING	11.10		09/10/	2013
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CHURCH AVE		
LUTHER	AN COMMUNITY H	IOME			DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000371	483.35(i)						
SS=E	FOOD PROCURI						
		RE/SERVE - SANITARY					
	The facility must						
		from sources approved or actory by Federal, State or					
	local authorities;						
		e, distribute and serve food					
	under sanitary co						
	Based on obse	rvation, record review,	F0003	371	F 371 Food Procure,		10/07/2013
	and interview, t	the facility failed to			Store/Prepare/Serve - Sanitary	ı.lt	
		9, receiving food			is the policy of this facility to		
		e dining room were			procure food from sources		
		a sanitary manner			approved or considered		
		n steam tables, hand			satisfactory by Federal, State of local authorities and to store,	וכ	
	•				prepare, distribute, and serve		
	washing and gl	love use.			food under sanitary		
					conditions.Corrective Action of	:	
	Findings includ	e:			Resident Affected: No resident	s	
					were affected.Other Residents		
	_	entrance tour kitchen			Having the Potential to be		
		n 9/3/13 at 7:30 a.m.,			Affected: All residents in the facility have the potential to be		
	Cook # 7 was s	serving breakfast trays.			affected.Systemic Changes an		
	She removed h	ner gloves, left the			Steps to Assure Deficient	-	
	kitchen, then re	eturned and washed			Practice Does Not Recur: Staff	f	
	her hands for a	pproximately 5			education was provided to the		
		returned to the serving			Dietary staff on September 11,		
		ed to dipping the food.			2013 and with all of the nursing	9	
		and make and an area.			staff beginning September 25,		
	Cook # 7 was a	again observed on the			2013 and will be complete by 10-07-2013. Content of the		
		oreakfast on 9/3/13 at 8			education included review of		
	_	lled bread while			Standard Precautions policy,		
					Food Service Sanitation policy		
		, making toast. She			and general glove use and har	nd	
	•	ood onto plates, then			washing. (Attachment		
		read from the toaster.			14 titled Infection Control - Foo	od	
	_	squeeze bottle of jelly			Handling). Monitoring of		
	on the cart whi	le wearing the same			Corrective Action : Random dining room audits will be		
					diming room addits will be		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet Page 17 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building 00			COMPLETED	
		155715				09/10/	2013
			B. WIN		DDDFGG CITY CTATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
	A N.I. O O D AD ALL IN LITTY / I	IOME			CHURCH AVE		
LUTHER	AN COMMUNITY F	HOME		SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	gloves. Still we	earing the gloves, she			completed weekly that will cov	er	
	squeezed ielly	onto toast, cut the			the main dining room and all		
		on a plate and served			satellite dining areas. The Die		
		She continued to			Manager will also complete da		
					audits five days per week in th	е	
		e gloves while serving			kitchen. (Attachment 15 titled Dietary Observation Tool). Au	ıdit	
		wing to the residents in			results will be reviewed by the		
	the assist dinir	ng room.			Quality Assurance Committee		
					monthly for three months. If		
	2. Interview w				appropriate practice is observe		
	_	/5/13 at 1:30 p.m.,			100% of the time, daily audits		
	indicated the c	ook should have			be stopped and random audits		
	removed her g	loves and washed her			will begin weekly. If opportunit		
	hands before h	nandling food after			for improvement are identified through the weekly audit, a full		
		lly bottle. She also			audit will resume. If after six		
		taff knew they should			months of random audits, 100	%	
		ds for at least 20			compliance continues, auditing		
		lus ioi at least 20			will stop.	,	
	seconds.				·		
	0 0 0 0 10 =	1 1 2 2 0 0 D M CNA #4					
		t 12:00 P.M., CNA #1					
		in the dining room,					
	1	, and touched papers					
	with diet instru	ctions on it. CNA #1					
	walked over to	a resident's table and					
	leaned over the	e table, placing her					
		and on the table. CNA					
	• •	team table and began					
		_					
		al portions for multiple					
		A #1 left the area and					
		no gloves on her hands.					
		oves and took a plastic					
	seal off severa	l prepared pies. CNA					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet Page 18 of 42

	I OF CORRECTION IDENTIFICATION NUMBER:  155715	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COM	PLETED 0/2013		
	PROVIDER OR SUPPLIER RAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE  111 W CHURCH AVE SEYMOUR, IN 47274					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	#1 cut the pies and served them, moving a resident's silverware with her gloved hands. CNA #1 returned to the steam table and began to serve other residents. CNA #1 removed gloves and did not wash her hands after removing the gloves. CNA #1 returned to the kitchen counter and took the plastic seal off a pie, cut the pie and served the pie without gloves on. When she had completed serving, she sat down next to a resident to assist in feeding him.  4. On 9-5-13 at 9:05 A.M., a review of a policy titled "Standard Precautions" indicated "Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments."  5. On 9-6-13 at 9:40 A.M., a review of the policy titled "Procedure for glove use" indicated "You are to change into clean gloves anytime you go to do other job duties"  6. On 9-6-13 at 9:50 A.M., a review of the policy titled "Food Service Sanitation" indicated "4. Plastic gloves are useful when the hands will						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet

Page 19 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155715		A. BUI	LDING	NSTRUCTION  00	(X3) DATE : COMPL 09/10/	ETED	
	PROVIDER OR SUPPLIEF		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE CHURCH AVE UR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	there is a sore Plastic gloves contaminated, should be replay when this occu	ntact with food or when or burn on the hand. may also become like the hand, and aced with clean gloves ars"					
	steam table on an old dried su serving the lun hood also had on it. There we	the dementia unit had bstance on it prior to ch meal. The plastic a dried food substance ere 29 residents in the being served from the					
	12:35 P.M., CN dried substance was to be cleated staff. She furth	view, on 9-3-13 at NA #1 indicated the e on the steam tray nsed by the kitchen her indicated that she eam tables were a day.					
	of a form titled List) indicated	at 9:00 A.M., a review "Cooks Help (Cleaning "take racks out of ean, then wipe out the					
	of a policy titled Sanitation - Eq Cleaning and S	at 11:20 P.M., a review d "Food Service uipment and Utensils - Sanitizing" indicated ntact surfaces of grills,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet

Page 20 of 42

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
		155715	B. WIN	_		09/10/	۷۱۱۵
NAME OF P	ROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP CODE		
					CHURCH AVE		
LUTHER	AN COMMUNITY F	HUME		SEYMO	DUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	-	imilar cooking devices					
		s and door seals of					
		ens shall be cleaned at					
		ayThe food-contact					
		cooking equipment					
	-	ee of encrusted grease					
		ther accumulated					
	soil"						
	3.1-21 (i)(3)						
							<u> </u>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet Page 21 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155715	B. WIN		<del></del>	09/10/	2013
			В. WПV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CHURCH AVE		
LUTHER	AN COMMUNITY H	IOME			OUR, IN 47274		
					7011, 114 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000428	483.60(c)						
SS=D		REVIEW, REPORT					
	IRREGULAR, AC						
	The drug regimen of each resident must be reviewed at least once a month by a						
	licensed pharmad						
	liceriseu priarriac	DIST.					
	The pharmacist n	nust report any					
		e attending physician, and					
	•	rsing, and these reports					
	must be acted up	on.					
	Based on reco	rd review and	F00	0428	F 428 Drug Regimen Review,		10/07/2013
	interview, the fa	acility failed to ensure			Report, Irregular, Act On. It is	the	
	the pharmacist				policy of this facility that the dr	ug	
	precautionary				regimen of each resident is		
					reviewed at least once per mo		
		ving tylenol on a			by a licensed pharmacist and t	:hat	
	_	RN (as needed) basis.			reports are made and acted		
	This affected 2	of 5 residents			upon.Corrective Action for Residents Affected: Orders for	· all	
	reviewed for ur	nnecessary			medications containing	all	
	medications. (	Residents # 20 and 68)			acetaminophen for resident #2	20	
					and #68 were reviewed. PRN		
	Findings includ	le:			administration was reviewed for	or	
		-			these residents over a 30-day		
	1 The clinical	record for Resident #			period and was calculated with	ı	
					any routine medication doses.		
		ed on 9/4/13 at 2:30			There were no instances of		
	•	ation use. The			exceeding the daily	. ^	
	resident had di	_			recommended limit of 4000mg	. A	
	included, but w	ere not limited to:			precautionary medication test with the statement "Do not		
	stroke, intracta	ble pain, and			exceed 4000mg of		
	osteoarthritis.	The most recent			acetaminophen daily " was add	ded	
	physician rewri	te orders, dated			to the EMR system to attach to		
		ed the medications			medications containing		
		ere not limited to the			acetaminophen. This medication	on	
	•				test was added to each		
		nol Extra Strength 500			medication containing		
		) one capsule daily			acetaminophen for these		
	, •	date was 5/6/13);			residents. (Attachment 11 title		
	Tylenol 325 mg	g 2 tabs prn (as			Medication Test Example). Ot	her	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet

Page 22 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00 COMPI	ETED
155715 A. BUILDING — 09/10	/2013
B. WING	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE	
111 W CHURCH AVE	
LUTHERAN COMMUNITY HOME SEYMOUR, IN 47274	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
necessary) q4h (every 4 hours) for Residents Having the Potential to	
pain or fever (original order date was be Affected: All residents taking	
5/6/13); and Tylonol Arthritis 650 mg	
O table 20th a manufactual triangle manufactual to be affected. The medication	
for pain (original order date was reviewed for usage of	
5/6/13). acetaminophen. Those residents with the potential to exceed	
4000mg daily based upon their	
The Medication Administration routine orders in addition to use	
Record (MAR) for June, 2013 July, of every prn dose available were	
2013 and August, 2013 were identified. PRN administration	
reviewed. The MARs indicated the was reviewed for these residents	
resident had received the prn Tylenol over a 30-day period and was	
The calculated with any folline	
only one time on 8/25/13 during the medication doses. There were no	
three months reviewed. There were instances of exceeding the daily	
no precautionary statements for what recommended limit of 4000mg. A	
would constitute an excessive dose precautionary medication test	
for the resident on any of the orders with the statement "Do not	
or in the resident's chart.  exceed 4000mg of acetaminophen daily" was added	
to the EMR system to attach to	
The pharmacist had reviewed the medications containing	
resident's medication orders on acetaminophen. This medication	
test was added to each	
5/28/13 and 6/24/13 with no Tylenol   medication containing	
recommendations. acetaminophen for each of these	
residents. A care plan for	
2. The clinical record was reviewed acetaminophen use was added to	
on 9/5/13 at 8:55 a.m. for Resident #	
69. He had diagnoses which (Attachment 12 titled	
Acctaninophen wanting care	
modination test with the	
and dementia.	
exceed 4000mg of	
The physician rewrite orders for acetaminophen daily" was added	
medications, most recently reviewed to the EMR system. During	
by the physician on 8/3/13 indicated review of new and admission	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building			COMPL	ETED
		155715	1			09/10/	′2013
			B. WIN		ADDRESS CITY STATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
LUTUED		IOME			CHURCH AVE		
LUTHER	AN COMMUNITY F	HOME		SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the resident wa	as receiving Norco			orders each business day, DC	N	
	5/325 (5 milligr	ams [mg.] of			or designee will assure the		
	, ,	and 325 mg of Tylenol)			medication test with the		
		very 4 hours) for pain			precautionary statement is attached to any orders for		
	•	red 8/22/12). In			medications containing		
	, •	was an order for			acetaminophen. An audit of 6		
					residents per week will be		
	Tylenol 325 2 tabs q4h prn (as				conducted to assure they have	е	
	• / \	iginally ordered on			not exceeded the recommend	ed	
	8/22/12).				daily dosage limit. (Attachme		
					titled 13 Acetaminophen Audit	t).	
	The Medication	n Administration			Nursing staff education was		
	Record (MAR)	for July, 2013, August,			completed beginning September 25, 2013 and will be complete		
	2013, and Sep	tember, 2013 was			10-07-2013. (Attachment 9 tit	•	
		resident had received			2013 Annual Survey Plan of	ieu	
		y once on 7/27/13,			Correction). The pharmacy wi	II	
		3, 8/27/13, and 9/13/13.			review for routine regimens th		
					would exceed the recommend		
		dition to the 1950 mg of			daily acetaminophen dosage		
	i yienoi with th	e Hydrocodone.			limits and notify the facility of a	-	
	l				concerns.Monitoring of Correct	ctive	
	•	t had reviewed the			Action: Audit results will be		
	resident's med	ications on 1/23/13,			reviewed by the Quality Assurance Committee monthl	.,	
	2/26/13, 3/18/1	3, 4/22/13, 5/28/13,			for six months. If appropriate	у	
	6/25/13, and 8	/27/13. There were no			documentation is completed		
	recommendation	ons for a precautionary			100% of the time, weekly audi	its	
	statement on a				will be stopped and monthly		
		ons for any of the			audits will begin. A sample siz	e of	
	Tylenol orders	•			25% will be completed. If		
	l yichor orders	•			opportunities for improvement	are	
	2 Intervious	ith the Director of			identified through the random	ıŧ	
		ith the Director of			audit, a full audit will resume. after 6 months of random aud		
	J	5/13 at 10:30 a.m.,			100% compliance continues,	ııə,	
		nad contacted the			auditing will stop.		
	pharmacist. S	he indicated he had					
	indicated he di	d not recommend a					
	precautionary	statement until the					
		lose to or over the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MU AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUIL 155715 B. WING			LDING	NSTRUCTION  00	(X3) DATE S COMPLI 09/10/2	ETED	
	ROVIDER OR SUPPLIER		e. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE CHURCH AVE DUR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)  dose.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	4. Review of the Handbook, from facility, on page following: "Ir dosages: Adult every 4 to 6 how extended-releasion mouth) every 8 (grams) daily. don't exceed 2	e Nursing 2013 Drug In the A Unit of the E 67, indicated the Indications and Its: 325 to 650 mg Iurs. Or, two Ise caplets P.O. (by Inhours. Maximum, 4 g For long term therapy, Its g daily unless Improved the service of the service					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet Page 25 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155715	B. WING		09/10/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R		CHURCH AVE	
LUTHER	AN COMMUNITY I	HOME		OUR, IN 47274	
				1	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000431 SS=D	& BIOLOGICALS The facility must	S, LABEL/STORE DRUGS			
		stem of records of receipt of all controlled drugs in			
	-	o enable an accurate			
		nd determines that drug			
		der and that an account of			
		gs is maintained and			
	periodically reco	nciled.			
	Drugs and biologicals used in the facility				
		in accordance with currently			
		sional principles, and opriate accessory and			
		ctions, and the expiration			
	date when applic				
		ith State and Federal laws,			
	· ·	store all drugs and			
		ked compartments under ure controls, and permit only			
		onnel to have access to the			
	keys.	inici to have access to the			
	The facility must	provide separately locked,			
		ked compartments for			
	_	olled drugs listed in			
		e Comprehensive Drug			
		n and Control Act of 1976 subject to abuse, except			
		uses single unit package			
		systems in which the			
	_	s minimal and a missing			
	dose can be read				
	Based on obse	ervation, interview and	F000431	F 431 Drug Records, Label/St	ore 10/07/2013
		the facility failed to		Drugs and Biologicals. It is th	
	have a control	•		policy of this facility to provide	
		dication (morphine)		separately locked, permanent	
	3453(41106/1116)	a.cadon (morphino)		affixed compartments for stora	age

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet

Page 26 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) I			X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPLI	ETED
		155715	B. WIN			09/10/2	2013
		<u> </u>	b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			CHURCH AVE		
LUTUED	AN COMMUNITY H	JOME			DUR, IN 47274		
LUTTIEN	AN COMMONTT I	IONE		SETIVIC	OOK, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	stored in a locl	ked narcotic box, in a			of controlled		
	locked medica	tion cart in 1 of 3			medications.Corrective Action		
	medication car	ts reviewed for			Resident Affected: No resident		
	medication sto	rage.			were affected.Other Residents Having the Potential to be	•	
		901			Affected: All residents have the	۵	
	Findings include	40:			potential to be affected. All		
		ie.			medication carts and medication	on	
	0-0540	7.40 A M dod			rooms were audited to assure		
		7:12 A.M., during on			appropriate storage of narcotic	;	
		a narcotic count			medications.Systemic Change		
	between night	shift and day shift			and Steps to Assure Deficient		
	nurses, RN#2	and LPN #3 discovered			Practice Does Not Recur: Nurs	~	
	a bottle of mor	phine was missing from			staff in-service provided to rev	iew	
	the locked med	dication cart. LPN #3			the facility policy for narcotic	_	
		nad administered the			medication storage. Education begun on September 25, 2013		
		the resident around			and will be complete by	'	
		7:21 A.M. the bottle			10-07-2013. (Attachment 9 titl	led	
					2013 Annual Survey Plan of		
		d by LPN #3 in an open			Correction). One medication of	cart	
		al sign cart. LPN #3			per week will be randomly		
	indicated she r				selected for auditing to assure		
	medication on	the vital sign cart when			narcotics are properly stored.		
	she was monit	oring the resident's vital			(Attachment 18 titled Medication	on	
	signs before a	nd after administrating			Cart Audit). Monitoring of	_	
	the medication	•			Corrective Action: Audit results		
					will be reviewed by the Quality Assurance Committee monthly		
	On 0 5 13 at 2	:52 P.M. a policy titled "			for six months. If	′	
		stances" indicated			appropriate procedure is follow	ved	
					100% of the time, weekly audi		
		substances must be			will be stopped and monthly		
	stored in a sep				audits will begin. If opportunitie		
	container" in	the medication			for improvement are identified		
	room/cart.				through the random audit, a fu	11 ]	
					audit will resume. If after 6	n/	
	During an inter	view on 9-5-13 at 2:15			months of random audits, 100 compliance continues, auditing		
	P.M., the Direct				will stop.	9	
	<u>-</u>	'controlled substances"			wiii stop.		
	were to be loci	ked in the lock box in					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155715	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	09/10	LETED 1/2013
	PROVIDER OR SUPPLIE AN COMMUNITY I		111 W	ADDRESS, CITY, STATE, ZIP ( CHURCH AVE DUR, IN 47274	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	the nurse's loc	ked cart.				
	3.1-25(n)	ked Cart.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet

Page 28 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155715	B. WIN	G		09/10/	2013
LUTHER	PROVIDER OR SUPPLIER	HOME	STREET ADDRESS, CITY, STATE, ZIP CODE  111 W CHURCH AVE  SEYMOUR, IN 47274		CHURCH AVE		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
F000514 SS=D	SSIBLE The facility must each resident in a professional stan are complete; acc readily accessible organized.  The clinical recor information to ide of the resident's a care and services any preadmission the State; and pro  Based on reco interview, the f accurately doc for 1 of 19 residence accurate docur #117)  Findings include Resident #117 record, with the 3/30/13, was re 3:26 p.m. Adm included, but w fibrillation, anxi disorder, hyper pressure), and #117's "Admiss dated 3/31/13,	rd review and acility failed to ument pressure ulcers dents reviewed for mentation. (Resident	F00	00514	F 514 Records - Complete and Accurate Documentation. It is policy of this facility to maintain clinical records that are comple accurately documented; readil accessible; and systematically organized. Corrective Action for Resident Affected: Resident # had already been discharged from the facility. Other Resident Having the Potential to be Affected: Each resident with a pressure area has the potential be affected. Documentation were viewed for each resident have a pressure area over a 30-day period and any inconsistencies were addressed with the nursi staff involved. Systemic Chang and Steps to Assure Deficient Practice Does Not Recur: Nurs staff education was initiated or September 25, 2013 and will be completed by 10-07-2013. Stawill begin to only document	the n ete; ly n 117 117 ats al to as ving n nes sing n oe	10/07/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet

Page 29 of 42

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155715	A. BUII B. WIN	LDING		09/10/	2013
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			CHURCH AVE		
LITHED	AN COMMUNITY H	IOME			DUR, IN 47274		
LUTTIEN	AN COMMONTTT	IONE		SETIVIC	JOK, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Heel: Pressure	Ulcer."			whether or not a wound was		
					present on admission for the		
	A review of "SI	kin Condition Report			initial entry. This will help to eliminate a discrepancy in this		
	Without Image	s" documentation from			area. The skin and wound		
	3/31/13 - 5/13/	13, and provided by			documentation workflow was		
		Nursing (DON) on			updated to reflect this change.		
		a.m., indicated that			(Attachment 19 titled		
		's right and left heel			Skin/Wound, Daily Pressure	- N	
		s were intermittently			Ulcer Documentation). The DO		
	documented as	•			or designee will review/audit the documentation of each resider		
		d "not present on			with a pressure ulcer on a wee	-	
		•			basis to assure there are no	J. U. y	
		oughout multiple			inconsistencies in documentat	ion	
		dates. Examples			as to whether or not a wound	was	
	include, but are	e not limited to:			present upon admission.		
					(Attachment titled 20 Weekly		
	- "3/31/201	3 2:33:51AM New (1st			Wound Documentation Audit).		
	recording) for s	site-488. Present on the			Monitoring of Corrective Action  Audit results will be reviewed I		
	Right Heel is a	Pressure UlcerThis			the Quality Assurance Commi	•	
	wound was pre	esent on admission."			monthly for six months. If		
					appropriate documentation is		
	- "3/31/201	3 2:34:50AM New (1st			completed 100% of the time,		
		site-408. Present on the			weekly audits will be stopped	and	
		Pressure UlcerThis			monthly audits will begin. A		
		esent on admission."			sample size of 25% will be completed. If opportunities for	-	
					improvement are identified		
	"A/1/12 5·	30:00PM Skin and			through the random audit, a fu	II	
					audit will resume. If after 6		
		to Site-408. Present			months of random audits, 100		
		el is a Pressure			compliance continues, auditing	9	
		ound was not present			will stop.		
	on admission."						
	_	1:30:00PM Skin and					
	Wound update	to Site-488. Present					
	on the Right H	eel is a Pressure					
	UlcerThis wo	ound was not present					

PLAN OF CORRECTION  DENTIFICATION NUMBER:  155715  X1) PROVIDER/SUPPLIER/CLIA  X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING				(X3) DATE SURVEY COMPLETED 09/10/2013		
PROVIDER OR SUPPLIER		J. (12.)	STREET A	ADDRESS, CITY, STATE, ZIP CODE CHURCH AVE DUR, IN 47274		
SUMMARY S' (EACH DEFICIEN REGULATORY OR  On admission."  - "4/2/13 4 Wound update on the Left Hee UlcerThis wo admission."  - "4/2/13 4: Wound update on the Right He UlcerThis wo admission."  In an interview on 9/5/13 at 2: "I can't say for discrepancy."	IOME TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  :18:50AM Skin and to Site-408. Present el is a Pressure und was present on  20:05AM Skin and to Site-488. Present eel is a Pressure und was present on  with the Administrator, 14 p.m., she indicated, sure why there was a She further indicated ure ulcers were	B. WIN	STREET A	CHURCH AVE		(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet Page 31 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MU			JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155715	A. BUII B. WIN			09/10/	2013
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
LUTUED	A N.I. O O NANALINIITY / I.I	OME			CHURCH AVE		
LUTHERA	AN COMMUNITY H	OME		SETIVIC	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F009999						,	
	3.1-25 Pharma	acy Services	F00	9999	F 9999 Pharmacy Services. It	is	10/07/2013
		•			the policy of this facility to labe		
	(i) Over-the-cou	unter medications,			over-the-counter medications,		
	•,				prescription drugs, and biologic	cal	
		igs, and biologicals			in accordance with currently		
		lity must be labeled in			accepted professional		
	accordance wit	h currently accepted			principles.Corrective Action for	•	
	professional pri	inciples, and include			Resident Affected: All		
	the appropriate	accessory and			medications for resident #98 w		
		ructions, and the			checked and labeled according	g to	
	•	when applicable.			facility policy. Other Residents		
	expiration date	when аррисаые.			Having the Potential to be Affected: All residents have the	_	
	<b>-</b>				potential to be affected. All	5	
	This state rule	was not met as			medication carts and medication	าท	
	evidenced by:				rooms were audited to assure	211	
					appropriate labeling of		
	Based on obse	rvation, interview and			over-the-counter/brought from		
	policy review th	ne facility failed to label			home medications.Systemic		
		er medications, with			Changes and Steps to Assure		
		ived from physician,			Deficient Practice Does Not		
		on in 1 of 5 residents			Recur: Nursing staff in-service		
					provided beginning September		
	,	g a medication pass.			25, 2013 and will be complete		
	(Resident #98)				10-07-2013 to review the facili	ty	
					policy for labeling of over-the-counter/brought from		
	Findings includ	e:			_		
	<b>-</b>				home medications. Staff were educated to assure medication	ie	
	On 9-5-13 at 8	:20 A.M., LPN #4 was			are labeled at the time they are		
	-	aring medications for			brought in to the building.	-	
		_			(Attachment 9 titled 2013 Annu	ıal	
		The over- the-counter			Survey Plan of Correction). Or		
	medications: V	·			medication cart per week will b	e	
	•	nd Fish Oil had been			randomly selected for auditing	to	
	labeled with res	sident's name. The			assure appropriate labeling.		
	label did not ind	clude directions for use			(Attachment 18 titled Medication	on	
	of the medication	on that included: name			Cart Audit). Monitoring of		
	of drug, dosage				Corrective Action: Audit results		
l	or drug, dosaye	S and time of			will be reviewed by the Quality		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet Page 32 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155715	B. WING		09/10/2013		
		1		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIEI	R		CHURCH AVE			
LUTHER	AN COMMUNITY H	HOME		OUR, IN 47274			
				1	775		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)			
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE		
		as directed by the		Assurance Committee monthly for six months. If	/		
	physician.			appropriate procedure is follow	wed hew		
				100% of the time, weekly audi			
	During an inter	rview, on 9-5-13 at 2:02		will be stopped and monthly			
	P.M., the Direc	ctor of Nursing		audits will begin. If opportunitie	es		
		all medications should		for improvement are identified			
		resident's name and		through the random audit, a fu	II		
		sage according to the		audit will resume. If after 6	,		
	physician's ord	-		months of random audits, 100			
		.0.0.		compliance continues, auditing will stop.	<del>)</del>		
	On 0 5 12 ct 2	PAR D.M. a policy titled		wiii stop.			
		::25 P.M., a policy titled					
		edication Containers"					
		and indicated "Labels					
		ounter drugs include: a.					
	1	bel; The resident's full					
	name; The exp	piration date when					
	applicable; and	d Directions for use and					
	1	cessory/cautionary					
	statements"	,					
	3.1-25(j)						
	0.1 20()						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LWD111

Facility ID: 000347

If continuation sheet Page 33 of 42

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPL	ETED	
		155715	B. WING		09/10/	2013	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE  111 W CHURCH AVE SEYMOUR, IN 47274				
(X4) ID	-	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  COMPLE		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG			DATE	
R000000	_	esidential findings were ance with 410 IAC	R000000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept thi plan of correction as our credit allegation of compliance.	e e s s		

State Form Event ID: LWD111 Facility ID: 000347 If continuation sheet Page 34 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPL	ETED
		155715	A. BUII			09/10/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.			ADDRESS, CITY, STATE, ZIP CODE		
LUTUED	AN COMMUNITY H	IOME			CHURCH AVE		
LUTHERA	AN COMMUNITY H	IOME		SETIVIC	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000091	410 IAC 16.2-5-1	.3(h)(1-4)					
	Administration an	id Management -					
	Noncompliance						
	(h) The facility shall establish and implement						
		anual to ensure that					
		I facility objectives are					
	attained, to include (1) The range of s	——————————————————————————————————————					
	(2) Residents' rigi						
	(3) Personnel adr						
	(4) Facility operat						
		be made available to					
	residents upon re						
			R00	0091	R 091 Administration and		10/07/2013
	Based on recor	rd review and			Management. It is the policy of	of	
	interview, the fa				this facility to establish and		
		written policy for			implement written policies.		
	•				Corrective Action for Resident		
	resident discha	•			Affected: Resident #41 has		
		wed for discharged.			already been discharged from		
	(Resident #41)				facility. Other Residents Havir The Potential to be Affected: //	•	
					residents have the potential to		
	Findings includ	le:			affected upon discharge.	De	
					Systemic Changes and Steps	to	
	A record review	v of Resident #41's			Assure Deficient Practice Does		
		eview was conducted			Not Recur: Nursing education		
					was provided and will be		
		20 p.m. The record			complete by 10-07-2013 to		
		dent #41 was admitted			educate the staff on all of the		
	·	d admitting diagnoses			necessary components and		
	included, but w	ere not limited to,			documentation required with a		
	diabetes, osteo	parthritis and			discharge of the resident from	tne	
	hypertension.	Resident #41 was			facility. (Attachment 1 titled Discharge/Transfer Education)	١	
		nome on 6/14/13. No			A discharge/transfer form was		
	_	umentation was			developed to guide staff		
	located.				documentation. (Attachment 2	2	
	iodated.				titled Discharge/Transfer). The		
	la aa lateed	with the Nivers			Assisted Living Nurse Manage		
	In an interview				will audit all discharge records	to	
	Manager, on 9	/9/13 at 2:30 p.m., she			ensure that the appropriate		

State Form Event ID: LWD111 Facility ID: 000347 If continuation sheet Page 35 of 42

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155715	B. WIN			09/10/2013
NAME OF D	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	KOVIDER OR SUFFLIER			111 W (	CHURCH AVE	
	AN COMMUNITY F	HOME		SEYMO	OUR, IN 47274	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	•	DATE
	indicated that t				process was followed and the appropriate documentation	
		perwork" for Resident			occurred. (Attachment 3 titled	
		er indicated "She went			Admission/Discharge Audit).	
		son and he already			Monitoring of Corrective Action	
	knew what kind	d of meds she took."			Audit results will be reviewed to	· 1
	<u>-</u>				the Quality Assurance Commit monthly for six months. If	uee
		e "Discharge/Transfer"			appropriate documentation is	
	Policy provided	-			completed 100% of the	
		13 at 10:30 a.m.,			time, random audits will begin	. A
	included, but w	as not limited to, the			sample size of 25% will be	
	following:				performed. If opportunities for improvement are identified	•
					through the random audit, a fu	.
	- "Should t	he resident be			audit will resume. If after six	"
	transferred or	discharged for the			months of random audits, 100	%
	following reaso	ons, the basis for the			compliance continues, auditing	9
	transfer or disc	charge must be			will stop.	
	documented in	the resident's clinical				
	record by the r	esident's attending				
	physician: a. T	he transfer or				
	discharge is ne	ecessary for the				
	_	are, and the resident's				
		be met in the facility"				
		<b>-,</b>				
	- "Docume	ntation from the care				
	planning team	concerning all				
	ı ·	scharges must include,				
		and as they may				
		reason(s) for the				
		charge; b. That an				
		tice was provided to				
		nd/or representative				
		hat the resident and/or				
	· · · · ·	(sponsor) participated				
	in a predischar					
		e date and time of the				
	program, u. m					

State Form Event ID: LWD111 Facility ID: 000347 If continuation sheet Page 36 of 42

STATEMENT OF DEFICIENCIES				(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL		
		155715	B. WIN			09/10/	2013	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
LUTHERAN COMMUNITY HOME					CHURCH AVE PUR, IN 47274			
					OIX, IIX 47274			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
		charge; e. The new						
	location of the resident; f. The mode							
		on; g. A summary of the						
	•	all medical, physical,						
		ndition; i. Disposition of						
	medications; j.	Others as appropriate						
	_	ry; and k. The signature						
	of the person r	ecording the data in						
	the medical red	cord."						
		ischarge plan is						
	developed prior to the discharge or transfer."							
	The UDischaus	-/Tuenefeull Delieu						
	The "Discharge/Transfer" Policy							
	(above) was reviewed with the Nurse Manager, on 9/10/13 at 11:30 a.m.,							
		ted that she could not						
	provide discharge documentation for Resident #41 as outlined per the facility policy. She provided a copy of							
	the "Resident Data Sheet", dated 11/31/10, which had a discharge							
	•	I-written on the back,						
	•	She indicated the						
		ature under the						
		plete on Discharge of						
	Patient."	<b>.</b>						
	A review of Ph	ysician Orders, dated						
	6/14/13, and provided by the Nurse Manager 9/10/13 at 12:45 p.m., indicated, "Discharge from assisted living 1 time per day during Day"							

State Form Event ID: LWD111 Facility ID: 000347 If continuation sheet Page 37 of 42

	OF CORRECTION  IDENTIFICATION NUMBER:  155715	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 09/10/2013		
	PROVIDER OR SUPPLIER  AN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE  111 W CHURCH AVE SEYMOUR, IN 47274				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION		
	Review of "Progress Notes by Resident", dated 6/12/13 at 10:44 a.m., and provided by the Nurse Manager, on 9/10/13 at 11:30 a.m., indicated, "This nurse spoke with resident's son and POA and he said the family has decided to move resident to another facility instead of moving her to nursing unit herethe family will be here to move her on Friday morning. [Resident's son] states he spoke with resident last evening about this move. This nurse spoke with her doctor and informed him of the details - that we will be keeping her here until Friday morning. MD agreed this is ok."  Review of "Progress Notes by Resident", dated 6/14/13 at 3:03 p.m., and provided by the Nurse Manager, on 9/10/13 at 11:30 a.m., indicated, "Resident's son [Name of son], also POA for resident here to pick up resident from the facilityresident walked out of the building with her son using a walker at this time. Resident discharged from assisted living due to increasing dementia and needing more nursing care."					

State Form Event ID: LWD111 Facility ID: 000347 If continuation sheet Page 38 of 42

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/01/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:  155715	A. BUILDING  B. WING	00	COMPLETED 09/10/2013		
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  111 W CHURCH AVE SEYMOUR, IN 47274				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		

State Form Event ID: LWD111 Facility ID: 000347 If continuation sheet Page 39 of 42

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
		155715	B. WING		<del></del>	09/10/2013	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					CHURCH AVE		
LUTHERAN COMMUNITY HOME			SEYMOUR, IN 47274				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG					CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	410 IAC 16.2-5-1. Infection Control (d) Prior to admis required to have a including history of present infectious that the resident stuberculosis in an verified upon admithereafter.  Based on reconsinterview, the farm of the residents, in the lath statement that of tuberculosis (Resident's #5, #40, #41)  1. Record revices (Resident's #5, #40, #41)  1. Record revices (Resident's #5, #40, #41)  2. Record revices (Resident's #5, #40, #41)  2. Record revices (Resident's #5, #40, #41)  3. Record revices (Record revices #5)  4. Record revices (Record revices #5)  5. Record revices (Record revices #5)  6. Record revices (Record revices #5)  7. Record revices (Record revices #5)  8. Record revices (Record revices #5)	2(d) - Noncompliance sion, each resident shall be a health assessment, of significant past or sidiseases and a statement shows no evidence of ninfectious stage as nission and yearly  rd review and acility failed to ensure a sample of 7, had a nt that included a the resident was free in an infectious state. #7, #14, #29, #31,  ew, on 09/09/13 at Resident #31 is free of an infectious state.  Resident #31 is free of an infectious state.  ew, on 09/09/13 at Resident #31 is free of an infectious state.	R00		R 409 Infection Control. It is the policy of this facility that prior the admission, each resident shall required to have a health assessment, including history significant and past infectious diseases and a statement that resident shows no evidence of tuberculosis in an infectious state as verified upon admission and yearly thereafter. Corrective Action for Resident Affected: Resider #29, 31, 14, 5, 7, 40, and 41 had the appropriate annual statement "Patient is free of communicable disease including infectious TB" signed by their physician. Other Residents Harthe Potential to be affected. All residents have had the appropriate annual statement "Patient is free of communicable disease including infectious TB signed by their physician. Systemic Changes a Steps to Assure Deficient Practice Does Not Recur: The statement "Patient is free of communicable disease including infections TB statement "Patient is free of communicable disease including infections TB statement "Patient is free of communicable disease including infections TB statement "Patient is free of communicable disease including infections TB statement "Patient is free of communicable disease including infections TB statement "Patient is free of communicable disease including infections TB statement "Patient is free of communicable disease including infections TB statement "Patient is free of communicable disease including infections TB statement "Patient is free of communicable disease including infections TB statement "Patient is free of communicable disease including infections TB statement "Patient is free of communicable disease including infections TB statement "Patient is free of communicable disease including infections TB statement "Patient is free of communicable disease including infections TB statement "Patient is free of communicable disease including infections TB statement "Patient is free of communicable disease including infections TB statement "Patient is free of communicable disease including infections TB statement "Patient is free	ne o be of the age d stion ave ng ving I e	
	-				infectious TB" will be added to	the	

State Form Event ID: LWD111 Facility ID: 000347 If continuation sheet Page 40 of 42

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	(3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD		00	COMPLETED	
		155715	B. WIN			09/10/	2013
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1	CHURCH AVE		
LUTHERAN COMMUNITY HOME					DUR, IN 47274		
LUTTIER	AN COMMONT I	IOME		SETIVIC	OCK, IN 47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	a physical asse	essment, dated			Annual Physical Form signed I	by	
	09/25/12, that	did not include a			the physician. (Attachment		
	statement that	Resident #14 is free of			16 titled Annual Physical Form	1).	
	tuberculosis in	an infectious state.			The Assisted Living Nurse  Manager will complete an audit of		
	13.50.00.00.00.00.00.00.00.00.00.00.00.00.	and an out-			all new admissions to ensure t		
	A Record rovi	ew, on 09/10/13 at			the form is completed accurate		
					(Attachment 17 titled Yearly	, -	
		Resident #7 indicated a			Physician Form Audit). Audit		
	1	sment, dated 07/17/13,			results will be reviewed by the		
		lude a statement that			Quality Assurance Committee		
	Resident #7 is	free of tuberculosis in			monthly for six months. If		
	an infectious state.				appropriate documentation is		
					completed 100% of the time, random audits will occur montle	als.	
	5. Record revi	ew, on 09/9/13 at 2:00			A sample size of 25% will be	ııy.	
		ent #29, indicated a			completed. If opportunities for		
	l ·	sment, dated 11/12/12,			improvement are identified		
	' '				through the random audits, a f	ull	
	that did not include a statement that				audit will resume. If after six		
Resident #29 is free of tuberculos					months of random audits 100%	6	
	an infectious state.				compliance continues, auditing	3	
					will stop.		
	6. Record revi	ew, on 09/09/13 at					
	2:30 p.m., for F	Resident #41, indicated					
	a physical asse	essment, dated					
	' '	did not include a					
		Resident #41 is free of					
		an infectious state.					
		an inicollous state.					
	7 Docard ravi	ow on 00/00/12 of					
		ew, on 09/09/13 at					
	•	Resident #40, indicated					
		essment, dated					
	06/22/12, that did not include a statement that Resident #7 is free of tuberculosis in an infectious state.						
	During an inter	view, on 09/10/13 at					
	•	Nurse Manager					
	10.00 a.m., the	, italise manager					

State Form Event ID: LWD111 Facility ID: 000347 If continuation sheet Page 41 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLETED			
155715			B. WING		09/10/2013
NAME OF P	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE	•
				CHURCH AVE	
LUTHER	AN COMMUNITY	HOME	SEYM	OUR, IN 47274	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	I	e don't do that here" in			
	. •	annual health			
	statement.				
		it 2:26 p.m., the Annual			
	Physical Asse				
	,	ective 02/01/10) was			
	l '	e Nurse Manager. The			
		of the policy indicates,			
		ual Physical health			
		vill include a history of			
		et or present infectious			
	diseases"				

State Form Event ID: LWD111 Facility ID: 000347 If continuation sheet Page 42 of 42